STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155254	A. BUILDING 00 B. WING	07/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR CREEK REHABILITATION CONVALESCENT CENTER	5430 WEST U.S. 40 GREENFIELD, IN46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00091349 completed on 6/15/11. This visit was in conjunction with a PSR to the Recertification and State Licensure completed on 5/12/11. Complaint IN00091349 - not corrected. Survey dates: July 11 and 12, 2011 Facility number: 000157 Provider number: 155254 AIM number: 100274720 Survey team: Barbara Gray RN Census bed type: SNF/NF: 48 Total: 48 Census payor type: Medicare: 6 Medicaid: 31 Other: 11 Total: 48 Sample: 4 These deficiencies reflect state findings	F0000	**This plan of correction is to serve as Sugar Creek Rehabilitation Convalescent Center's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Sugar Creek Rehabilitation Convalescent Center or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	cited in accordance with 410 IAC 16.2. Quality review completed 7/14/11 by Jennie Bartelt, RN.			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to thoroughly investigate an injury of unknown source that resulted in a right hip fracture for 1 of 1 resident reviewed for fracture, in a sample of 4.	F0225	**F225 483.13(c)(1)(ii)-(iii), (c)(2)-(4) INVESTIGATE/REPORT/ ALLEGATIONS/INDIVIDUALS** It is the practice of Sugar Creek	07/22/2011

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	(Resident #D) Findings include: Resident #D's record was reviewed on 7/11/11 at 3:45 P.M. Diagnoses included, but were not limited to, advanced dementia, osteoporosis, cerebral vascular accident (stroke) with left hemiplegia, bilateral hand and leg contractures, and seizure disorder. A quarterly Minimum Data Set assessment for Resident #D, dated 4/8/11, indicated she was rarely understood and rarely understood others, her cognitive skills for daily decision making were severely impaired, she was totally dependent on one person for bed mobility, dressing, personal hygiene, and toileting, she was totally dependent on two persons for transfer, and she did not walk. An interview with Resident #D's family on 7/11/11 at 3:33 P.M., indicated he believed Resident #D fractured her right hip on 6/28/11. Resident #D's family indicated Resident #D began moaning while receiving care that day. Resident #D's family indicated the fracture could have happened then or the fracture could have happened earlier in the day, he just didn't know. Resident #D's family indicated Resident #D had brittle bones		Rehabilitation Convalescent Center to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures including to the state survey and certification agency. I. The incident involving Resident D has been investigated to the degree it is possible at this time. II. All residents have the potential to be affected. This has been addressed by the systems described below. III. The facility policy regarding Abuse Prevention has been reviewed and amended. New reporting and investigation tools have been implemented to assist personnel in obtaining improved documentation of interviews and the conclusion of the investigation. In addition, the Administrator is reviewing the investigation and confidential statements and signing the final summary of findings. This confidential file is being maintained in the Administrator's office. Facility personnel have been educated on this new process.	

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	that could fracture easily. Resident #D's family indicated Resident #D fractured her left leg a couple years previously, just by a family member lifting her leg. An initial with follow up Facility Incident Reporting documentation provided by the Administrator on 7/11/11 at 3:00 P.M., indicated the following: Brief description of incident - CNA reported to writer when residents husband was putting bilateral lower multi-podus boots on resident, he elevated her leg and when doing so, resident moaned and grimaced. Type of injury - right hip fracture. Immediate action taken - Dr. and family notified. X-ray ordered and revealed right hip fracture. Preventive measures taken - bed rest times 2 weeks, all splints and multi-podus boots discontinued secondary to risks outweigh benefits, pain medicine ordered, resident evaluated for Hospice and picked up on caseload. An interview with the Administrator on 7/12/11 at 11:47 A.M., indicated she put the Assistant Director of Nursing (ADON) in charge of the investigation. The ADON interviewed staff members but the Administrator could not provide the investigation for review, indicating she was unable to locate the investigation. The ADON spoke with Resident #D's daughter about the fracture but did not		IV. The Administrator or her designee is completing quality improvement audits of all resident abuse allegations including incidents of unusual occurrence. Although the individual resident issues will be held confidential, the results of the audits will be discussed during the facility's quality assurance meeting monthly.	

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	interview Resident #D's husband. There were no findings and the results of the investigation were not documented on the Facility Incident Reporting form follow up. She did not receive the completed investigation from the ADON. Staff interviews were provided by the Administrator on 7/12/11 at 11:45 A.M., which she indicated were e-mailed to her from the ADON who was out of town the evening of 7/11/11. The Administrator indicated she had the staff who were interviewed, sign the e-mailed interviews, the morning of 7/12/11. 3 of the interviews were signed, with no time or date documented as to when they were signed. The Administrator indicated the other e-mailed interview would be signed by the CNA when she reported to work the evening of 7/12/11. The interviews indicated the following: 1.) (No date or time of interview documented.) This writer questioned CNA #1 in regards to Resident #D. CNA #1 stated she did not have Resident #D on her assignment the night of 6/28/11. CNA #1 stated she did have contact with Resident #D but never noted any distress or signs of pain. Resident #D acted and looked the same way she always did, nothing seemed different with her.			

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	2.) (No date or time of interview documented.) This writer questioned CNA #2 about putting Resident #D to bed. CNA #2 stated when putting Resident #D to bed, she did not notice anything different about her. When the writer asked if Resident #D moaned, groaned or displayed any facial grimacing, when putting her to bed, CNA#2 responded Resident #D did not do anything out of the ordinary. CNA #2 indicated she put Resident #D to bed with the Hoyer lift the same way she always did with the help of another CNA. CNA #2 indicated she would have notified the nurse if she thought anything was wrong with Resident #D. 3.) (No date or time of interview documented.) This writer was called to Resident #D's room by CNA #3. CNA #3 was in the middle of performing ADL's and reported Resident #D's right leg looked "different than usual". CNA #3 reported both of Resident #D's legs were usually pulled up tight but her right leg looked like it was loose or something. CNA #3 reported she had only washed the top half of Resident #D's body and had not yet moved her. 4.) (No date or time of interview documented.) CNA #4 reported to this writer she was getting Resident #D out of			

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	bed on 6/28/11. CNA #4 stated she completed Resident #D's care and transferred her to the wheelchair with the use of a Hoyer lift successfully. CNA #4 said she was cleaning up her mess and saw a family member putting Resident #D's splint-boot on her right leg. When Resident #D's right leg was lifted she groaned. CNA #4 reported Resident #D never made any further moans and had no facial grimacing or acted like she was having any pain. No further documentation related to the investigation was provided. This federal tag is related to Complaint IN00091349. This deficiency was cited on 6/15/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(d)			

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to follow the policy to thoroughly investigate an injury of unknown source that resulted in a right hip fracture for 1 of 1 resident reviewed for fracture, in a sample of 4. (Resident #D) Findings include: Resident #D's record was reviewed on 7/11/11 at 3:45 P.M. Diagnoses included but were not limited to advanced dementia, osteoporosis, cerebral vascular accident (stroke) with left hemiplegia, bilateral hand and leg contractures, and seizure disorder. A quarterly Minimum Data Set assessment for Resident #D, dated 4/8/11, indicated she rarely understood and rarely understood others, her cognitive skills for daily decision making were severely impaired, she was totally dependent on 1 person for bed mobility, dressing, personal hygiene, and toileting, she was totally dependent on 2 persons for transfer, and she did not walk.	F0226	**F226 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT POLICIES** It is the practice of Sugar Creek Rehabilitation Convalescent Center to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property.I. The incident involving Resident D has been investigated to the degree it is possible at this time. II. All residents have the potential to be affected. This has been addressed by the systems described below. III. The facility policy regarding Abuse Prevention has been reviewed and amended. New reporting and investigation tools have been implemented to assist personnel in obtaining improved documentation of interviews and the conclusion of the investigation. In addition, the Administrator is reviewing the investigation and confidential statements and signing the final summary of findings. This confidential file is being maintained in the Administrator's office. Facility personnel have been educated on this new process. IV. The Administrator or	07/22/2011

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	An interview with Resident #D's family on 7/11/11 at 3:33 P.M., indicated he believed Resident #D fractured her right hip on 6/28/11. Resident #D's family indicated Resident #D began moaning while receiving care that day. Resident #D's family indicated the fracture could have happened then or the fracture could have happened earlier in the day, he just didn't know. Resident #D's family indicated Resident #D had brittle bones that could fracture easily. Resident #D's family indicated Resident #D fractured her left leg a couple years previously, just by a family member lifting her leg. An initial with follow up Facility Incident Reporting documentation provided by the Administrator on 7/11/11 at 3:00 P.M., indicated the following: Brief description of incident - CNA reported to writer when residents husband was putting bilateral lower multi-podus boots on resident, he elevated her leg and when doing so, resident moaned and grimaced. Type of injury - right hip fracture. Immediate action taken - Dr. and family notified. X-ray ordered and revealed right hip fracture. Preventive measures taken - bed rest times 2 weeks, all splints and multi-podus boots discontinued secondary to risks outweigh benefits, pain medicine ordered, resident evaluated for Hospice		her designee is completing quality improvement audits of all resident abuse allegations including incidents of unusual occurrence. Although the individual resident issues will be held confidential, the results of the audits will be discussed during the facility's quality assurance meeting monthly.	

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	and picked up on caseload. An interview with the Administrator on 7/12/11 at 11:47 A.M., indicated she put the Assistant Director of Nursing (ADON) in charge of the investigation. The ADON interviewed staff members but the Administrator could not provide the investigation for review, indicating she was unable to locate the investigation. The ADON spoke with Resident #D's daughter about the fracture but did not interview Resident #D's husband. There were no findings and the results of the investigation were not documented on the Facility Incident Reporting form follow up. She did not receive the completed investigation from the ADON. Staff interviews were provided by the Administrator on 7/12/11 at 11:45 A.M., which she indicated were e-mailed to her from the ADON who was out of town the evening of 7/11/11. The Administrator indicated she had the staff who were interviewed, sign the e-mailed interviews, the morning of 7/12/11. Three of the interviews were signed, with no time or date documented as to when they were signed. The Administrator indicated the other e-mailed interview would be signed by the CNA when she reported to work the evening of 7/12/11. The interviews indicated the following:			

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	1.) (No date or time of interview documented.) This writer questioned CNA #1 in regards to Resident #D. CNA #1 stated she did not have Resident #D on her assignment the night of 6/28/11. CNA #1 stated she did have contact with Resident #D but never noted any distress or signs of pain. Resident #D acted and looked the same way she always did, nothing seemed different with her. 2.) (No date or time of interview documented.) This writer questioned CNA #2 about putting Resident #D to bed. CNA #2 stated when putting Resident #D to bed, she did not notice anything different about her. When the writer asked if Resident #D moaned, groaned or displayed any facial grimacing, when putting her to bed, CNA#2 responded Resident #D did not do anything out of the ordinary. CNA #2 indicated she put Resident #D to bed with the Hoyer lift the same way she always did with the help of another CNA. CNA #2 indicated she would have notified the nurse if she thought anything was wrong with Resident #D. 3.) (No date or time of interview documented.) This writer was called to Resident #D's room by CNA #3. CNA #3 was in the middle of performing ADL's			

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	and reported Resident #D's right leg looked "different than usual". CNA #3 reported both of Resident #D's legs were usually pulled up tight but her right leg looked like it was loose or something. CNA #3 reported she had only washed the top half of Resident #D's body and had not yet moved her. 4.) (No date or time of interview documented.) CNA #4 reported to this writer she was getting Resident #D out of bed on 6/28/11. CNA #4 stated she completed Resident #D's care and transferred her to the wheelchair with the use of a Hoyer lift successfully. CNA #4 said she was cleaning up her mess and saw a family member putting Resident #D's splint-boot on her right leg. When Resident #D's right leg was lifted she groaned. CNA #4 reported Resident #D never made any further moans and had no facial grimacing or acted like she was having any pain. No further documentation related to the investigation was provided. The most current abuse policy and procedure provided by the Administrator on 7/11/11 at 11:00 A.M., indicated the following. Policy statement - All reports of resident abuse, neglect and injuries of unknown source shall be promptly and			

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	thoroughly investigated by facility management. Policy interpretation and implementation - 1.) Should an incident or suspected incident of resident abuse, neglect or injury of an unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident. 2.) The Administrator will provide to the person in charge of the investigation a completed copy of the abuse report form, witness statement, and/or information regarding the alleged incident. 3.) The individual conducting the investigation will, at a minimum: a.) Review the resident's medical record to determine events leading up to the incident.; b.) Interview the person(s) reporting the incident; c.) Interview any witnesses to the incident; d.) Interview the resident (as medically appropriate); e.) Interview the resident's attending physician to determine the resident's current mental status; f.) Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; g.) Interview the resident's roommate, family members, and visitors; h.) Interview other residents to whom the accused employee provides care or services, and i.) Review all events leading up to the alleged incident... 4.) The following guidelines will be used when conducting interviews: a.) Each			

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	interview will be conducted separately and in a private location; b.) The purpose and confidentially of the interview will be explained thoroughly to each person involved in the interview process; and 5.) Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports... 8.) The individual in charge of the investigation will consult with the Administrator on a daily basis concerning the progress/findings of the investigation. 9.) The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. 10.) The results of the investigation will be documented. 11.) A copy of the completed investigation will be provided to the Administrator within 5 working days of the reported incident. 12.) The Administrator will inform the resident and his/her representative (sponsor) of the results of the investigation and corrective action taken within 5 days of the completion of the investigation...." This federal tag is related to Complaint IN00091349. This deficiency was cited on 6/15/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155254	A. BUILDING 00 B. WING	07/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUGAR CREEK REHABILITATION CONVALESCENT CENTER	5430 WEST U.S. 40 GREENFIELD, IN46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-28(a)			